Evidence-Based Practice: A Closer Look at TF-CBT

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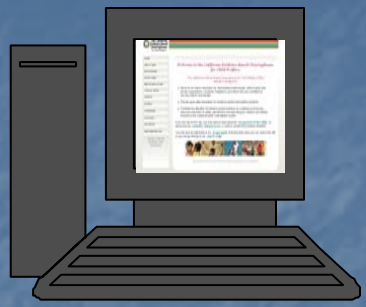
The California Evidence-Based Clearinghouse for Child Welfare (CEBC)

- In 2004, the California Department of Social Services, Office of Child Abuse Prevention contracted with the Chadwick Center for Children and Families, Rady Children's Hospital-San Diego in cooperation with the Child and Adolescent Services Research Center to create the CEBC.

- The CEBC was launched on 6/15/06.

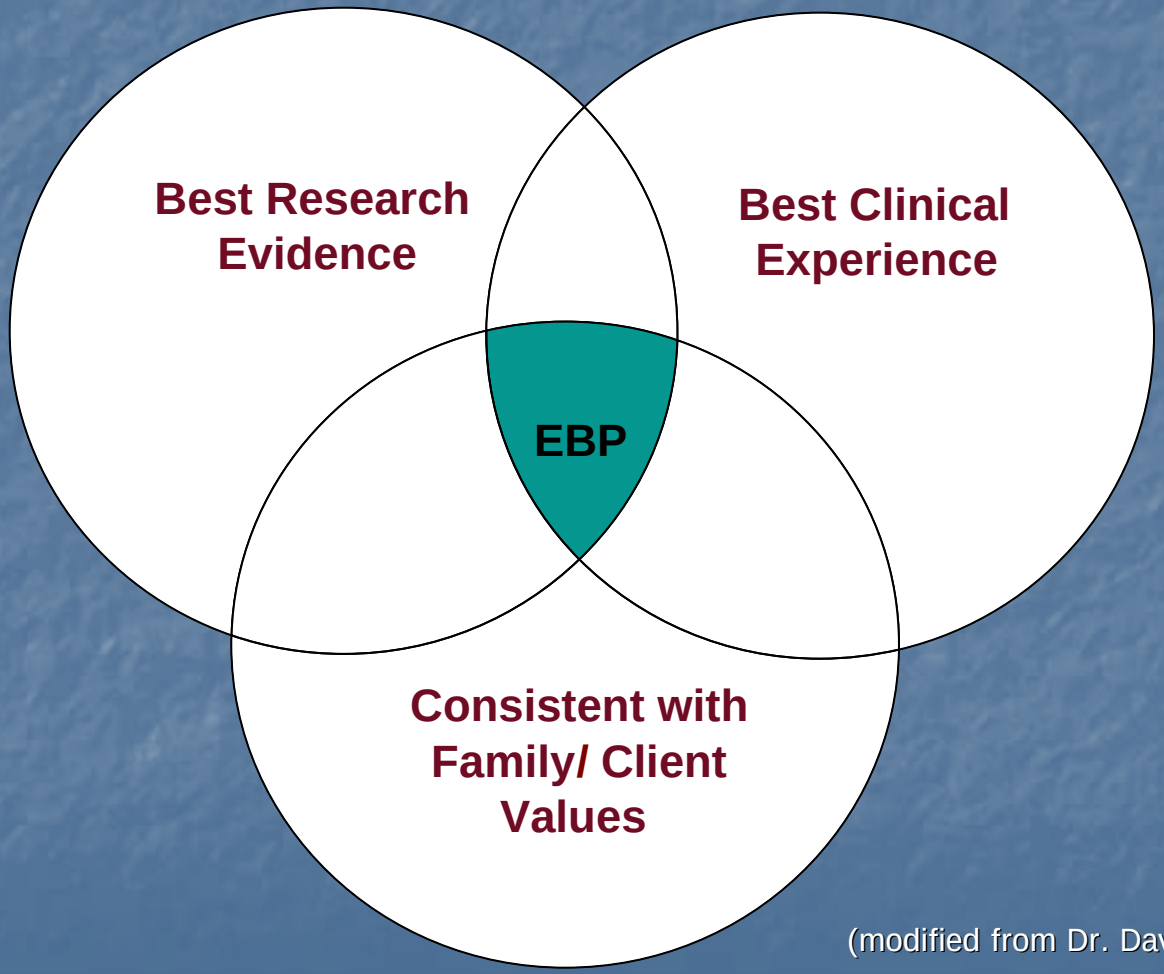
What is the CEBC?



The CEBC:

- **provides information on selected evidence-based practices through a user-friendly website.**
- **Presents brief and detailed summaries for each reviewed practice.**
- **is arranged in a simple, straightforward format reducing the need to conduct literature searches, or understand research methodology.**

CEBC's Definition of EBP for Child Welfare



(modified from Dr. David Sackett's definition)

Trauma Focused Cognitive Behavioral Therapy

TF-CBT

The California Evidence-Based Clearinghouse for Child Welfare

Rady Children's San Diego | Chadwick Center for Children & Families

What is TF-CBT?

- conjoint child and parent psychotherapy model
- for children who are experiencing significant emotional and/or behavioral difficulties related to traumatic life events
- a components-based hybrid treatment model
- incorporates trauma-sensitive interventions
- based on humanistic, cognitive-behavioral and family theory

Target Population

- Children who have experienced a trauma
- Children who are experiencing significant Post-Traumatic Stress Disorder (PTSD) symptoms, whether or not they meet full diagnostic criteria
- Children with depression, anxiety, and/or shame related to their traumatic exposure
- Children experiencing Childhood Traumatic Grief
- **Age range(s)**: 3-18

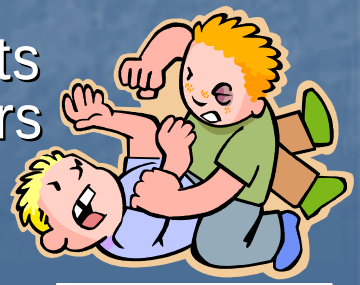
Is TF-CBT Appropriate for Everyone?

Include:

- Children with a trauma history
- Children with PTSD symptoms who have a caregiver or consistent adult who can be involved in treatment
- Children who do not have caregiver can also benefit

Exclude:

- Children with significant conduct problems present before the trauma
- In-vivo – contraindicated for children and adolescents with runaway behavior, suicidal and cutting behaviors



Importance of Early Intervention in Trauma Cases

- For ethical reasons studies are Treatment as Usual v. TF-CBT

- ACE study by Felliti looks at childhood adverse events and effects on future health...gives us a glimpse of effects of childhood trauma on adults.

http://www.acestudy.org/

TF-CBT Outcomes

- Multiple Randomized Controlled Trials (RCTs) with children ages 3-17
- TF-CBT v Treatment as Usual (TAU)
  - TFCBT resulted in greater improvement in anxiety, depression, sexual problems, dissociation, shame internalized and externalized problems in children
  - TF-CBT resulted in greater improvement in depression, parenting skills, parental support and decreased parental support

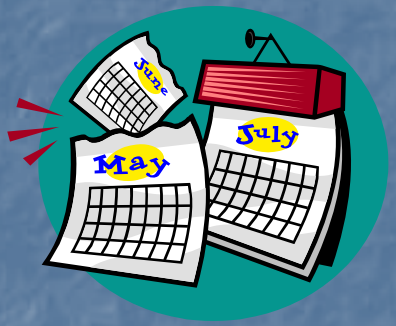
TF-CBT and Culture

- Culturally Modified Trauma Focused Treatment: Adaptation with Hispanic Children- Michael A. de Arellano, Ph.D. and Carla Danielson, Ph.D.

- Honoring Children Mending the Circle: Adaptation for Native Americans by Delores Bigfoot, PhD

Sustained Effects Over Time

- Improvements in PTSD, depression, and externalizing behaviors that were found at post-treatment were maintained across groups at:
  - 3 months
  - 6 months
  - 1 year
  - 2 year



- TF-CBT retained its advantage over Treatment as Usual at all follow-ups

Deblinger, E., Steer, R., & Lippmann, J. (1999)

Including Parents is Important

- Randomized Controlled Trial for 100 sexually abused children 8-14 years old
  and their non-offending parents
  - ***TF-CBT*** for child only
  - parent only, parent and child,
  - community treatment as usual (TAU).

- Children receiving ***TF-CBT*** experienced significantly greater improvement in PTSD symptoms.
- Parent involvement in treatment led to significantly greater improvement in depression and behavior problems in children and significantly greater improvement in parenting skills.
- Measures included the *Schedule for Affective Disorders and Schizophrenia for School-Age Children (K-SADS-E); Children's Depression Inventory (CDI); State-Trait Anxiety Inventory for Children (STAIC); Child Behavior Checklist (CBCL);* and *Parenting Practices Questionnaire.*

Deblinger, E., Lippmann , J., & Steer, R. (1996)

Location, Intensity and Duration

Location:

- Usually in office setting, but can be adapted to field or residential

Frequency, duration of intervention:

- **Recommended intensity**: Sessions are conducted once a week.

- **Recommended duration**: For each session: 30-45 minutes for child; 30-45 minutes for parent. The program model also includes conjoint child-parent sessions toward the end of treatment that last approximately 30-45 minutes. Treatment lasts 12-18 sessions.

Flexibility with the TF-CBT Model

- Clinical judgment and the child's individual situation may dictate that an alternative order be used in introducing the TF-CBT components
- This flexibility in sequencing is consistent with the model as long as all appropriate components are utilized at some point in the therapy process
- In many clinical situations, aspects of several components can be blended together in a single session to provide an optimal intervention

Trauma Focused Cognitive Behavioral Therapy

Psychoeducation and parenting skills

Relaxation

Affective Expression and Regulation

Cognitive Coping

Trauma Narrative Development and Processing

In Vivo Gradual Exposure

Conjoint Parent-Child Sessions

Enhancing Safety and Future Development

Parent Components

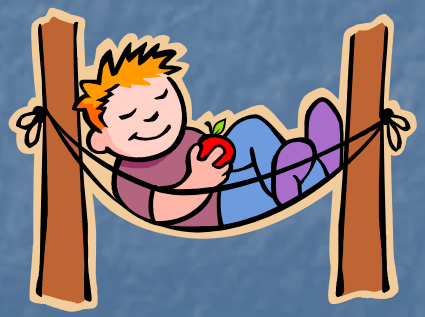
- Teach effective parenting skills
- Increase parental support of child
- Teach caretakers stress management skills
- Reduce inappropriate parenting practices
- Reduce parental trauma-related emotional distress
- Improve personal safety skills
- Enhance ability to manage trauma reminders and future stressors

Psychoeducation

- Teaching parent and child about sexual abuse and PTSD and typical reactions of victims
- Teach parent and child about healthy sexuality
- Educating parent on child behavior management skills

Relaxation

- Using relaxation tapes or scripts
- Practicing deep breathing/Belly Breathing
- Listening to music
- Progressive Muscle Relaxation



Affective Regulation

- **Feeling identification** is a relatively non-stressful way for children to begin talking about their feelings with the therapist.
- By sharing common everyday feelings with each other, the therapist is able to gauge the child's verbal and emotional ability to accurately identify and express a range of different feelings.
- The child gets to know a little about the therapist, sees that the therapist has had "bad" as well as "good" feelings, and that the therapist is open about sharing these feelings with the child.

Cognitive Coping

Cognitive Triangle

Identifying Thoughts versus Feelings

- Your mother blames you for something your little brother did.

  Thought: She's not being fair.

  Feeling: hurt, mad

- The next step is to encourage the child to learn how to **generate alternative thoughts that are more accurate, or more helpful**, in order to feel differently

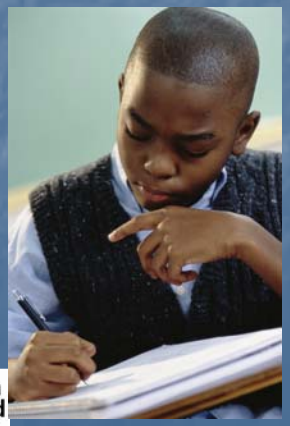
  More Accurate Thought: Mom won't be mad at me once she knows the truth.

  New Feeling: Hopeful

Trauma Narrative

- Goal = unpair thoughts, reminders, or discussions of the traumatic event, from overwhelming negative emotions such as terror, horror, extreme helplessness, or rage.

- Over the course of several sessions, the child is encouraged to describe more and more details of what happened before, during and after the traumatic event, as well as the child's thoughts and feelings during these times.



In Vivo Exposure

Desensitize child to “trauma cue” or “trigger”

- This is done at child’s pace and only after teaching them other components such as relaxation and cognitive coping.
- Creating the trauma narrative
- Other ways of having child face their fears includes “gradual exposure” to triggers (ex. scene of the crime). Especially critical for kids who need to continue to be around where the abuse took place (school, a room in their house etc)

Cognitive Coping Part II

- After trauma narrative is completed, directly explore and correct the child's cognitive errors (inaccurate or unhelpful thoughts).

- One way to do this is to re-read the child's trauma narrative book in session, with a focus on all of the thoughts the child expressed in the book. As each thought is verbalized in the book, the therapist should explore with the child whether this thought was accurate and helpful.

Conjoint Sessions

- Both parent and child are prepared for conjoint sessions ahead of time. Therapist has already shared trauma narrative with parent and taught parent about appropriate responses.
- Child reads trauma narrative aloud. At conclusion parent and therapist praise child for bravery.
- Child asks questions (prepared ahead of time and therapist has reviewed with parent ahead of time)
- Parent asks questions (also reviewed with therapist ahead of time)
- Therapist role is to allow child and parent to communicate directly to one another only intervening if there are difficulties (inaccurate or unhelpful cognitions that the other does not challenge)

Enhancing Safety and Future Development

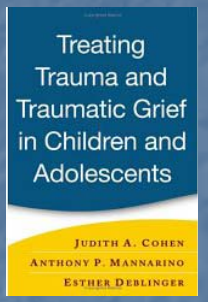
- Look at Safety Planning
- Further education about sexuality, abuse etc.
- Have child focus on other aspects of their life that define them to help them to increase positive outlook on life.

Staff Qualifications

- At least a Master's degree in behavioral science
- Training in the treatment model
- Experience working with children and families

Information on Training

- Treating Trauma and Traumatic Grief in Children and Adolescents, Cohen, Mannarino and Deblinger 2006.



- **Training contact**: Judith Cohen, M.D. jcohen1@wpahs.org or Esther Deblinger, Ph.D. deblines@umdnj.edu.

- **Number of days/hours**: Introductory Overview 1-8 hours
  Basic Training 2-3 days
  Advanced Training 1-3 days

- **Training is obtained**: National Conferences; CARES Institute, Allegheny General Hospital and onsite by request

- **List of additional qualified resources**: Ten-hour basic web-based training free of charge at www.musc.edu/tfcbt.

Additional Resources

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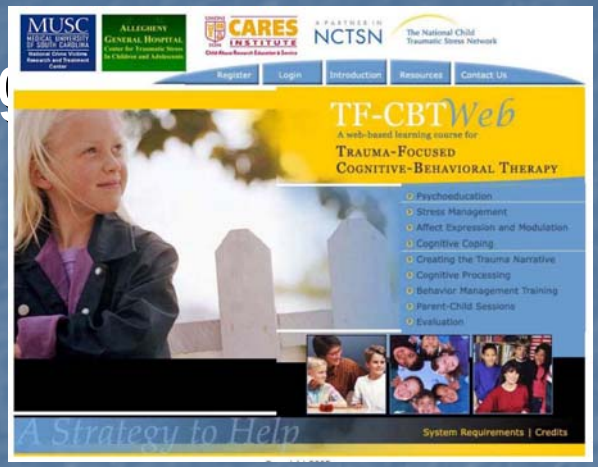
www.musc.edu/tfcbt



- Web Resources for more Information
  - Kauffman Best Practices Project
  - National Child Traumatic Stress Network
  - SAMHSA Substance Abuse and Mental Health Model Programs
  - U.S. Department of Justice sponsored report, Child Physical and Sexual Abuse: Guidelines for Treatment

Current Implementation in CA

- Breakthrough Series Participants from 2005/2006
  - Chadwick Center for Children and Families- San Diego
  - Children's Institute International- Los Angeles
- Current CIMH Implementation Project
  - San Luis Obispo – County Mental Health
  - San Francisco – County Mental Health (Family MOSAIC, Foster Care Mental Health)
  - Riverside – County Mental Health
- 713 people have completed the 10 hour web training in CA

Funding Issues

- TF-CBT is a mental health intervention and health insurances as well as Victims of Crime funding are used to pay for services.

- In San Diego county the county Child Welfare Services has contracted with Chadwick Center to provide these services for children who have been sexually abused and provides funding to do so.

Key Considerations for Implementation

Chadwick Center Implementation of TF-CBT in 2005

- **TF-CBT** was similar to previous interventions used by staff:
  - Shorter term and more structured
  - Used same therapy setting
- Therapists expressed concerns about training and supervision around using TF-CBT regarding the following elements:
  - Difficulty of Involving Parents
  - Sticking to Time Frames
  - Avoiding Getting Caught up in Crisis Of the Week (COWS)
  - Fidelity to the Model

Final Thoughts

- ✓ Create resources for therapists to share to talk about different ways to address the components
- ✓ It is critical to provide good training for both therapists and supervisors
- ✓ Ongoing consultation with experts is ideal

For Further Information

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